ARC 5487C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to home health agency services

The Human Services Department hereby amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code chapter 249A.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapter 249A and Public Law 116-136, Section 3708.

Purpose and Summary

These amendments allow physician assistants, nurse practitioners, and clinical nurse specialists to order and sign treatment plans for home health agency services provided to Iowa Medicaid members. These rules are being implemented based on Section 3708 of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law 116-136), which is applicable to services provided on or after March 1, 2020.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on December 16, 2020, as **ARC 5336C**. The Department received responses from four respondents/organizations. All four respondents supported the Department's amendments to Chapter 78, which allow physician assistants, nurse practitioners, and clinical nurse specialists to order and sign treatment plans for home health agency services provided to Iowa Medicaid members.

However, two respondents recommended technical changes to other Department rules to ensure that they align with federal home health agency regulations and the authority granted under the CARES Act. The respondents' comments suggesting changes to these rules and the Department's responses to these comments follow:

Comment 1: The respondents recommended changes to rule 441—79.3(249A), Maintenance of Records by Provider of Service. The respondents suggested adding the phrase "nurse practitioner, physician assistant, or clinical nurse specialist" after the word "physician" in paragraph "4" of subparagraph 79.3(2)"d"(27) with regard to orders for home health agency services.

Department response: The Department has made the recommended change to 79.3(2)"d"(27)"4."

Comment 2: The respondents also recommended that the Department amend rules about orders for other home health agency services in Chapters 83 and 177. The respondents stated that these changes would be comparable to the new authority provided by Section 3708 of the CARES Act and that the amended language would ensure better access to care for their patients and better recognize the role of nurse practitioners. More specifically, the respondents suggested adding "nurse practitioner" and "clinical nurse specialist" in paragraph 83.2(1)"e" and adding the phrase "nurse practitioner, clinical nurse specialist, or physician assistant" after the word "physician" in paragraphs 83.61(1)"k" and 83.82(1)"j." All three of these paragraphs relate to orders for interim medical monitoring and treatment for eligible Medicaid recipients. The respondents also recommended adding the phrase "nurse practitioner, physician assistant, or clinical nurse specialist" after the word "physician" wherever it appears in rule 441—177.3(249), Service Criteria.

Department response: The Department has amended paragraphs 83.2(1)"e," 83.61(1)"k," and 83.82(1)"j" as requested regarding orders for interim medical monitoring and treatment. However, the Department is unable to make the requested changes to rule 441—177.3(249A). Making these changes would require a change to the In-Home Health-Related Care (IHHRC) program statute, and the Department does not have the authority to amend statute.

Except for the changes described above, no changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on February 11, 2021.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on April 14, 2021.

The following rule-making actions are adopted:

ITEM 1. Amend rule 441—78.9(249A) as follows:

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, evidenced by the physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. to *g.* No change.

h. Member's medical condition as reflected by the following information, if applicable:

(1) and (2) No change.

(3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

(4) to (10) No change.

i. to *k.* No change.

l. Physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or physician assistant before the claim for service is submitted for reimbursement.

78.9(2) No change.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant and included in the plan of care. Other daily skilled nursing visits

which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. No change.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase

the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) to **78.9(11)** No change.

This rule is intended to implement Iowa Code section 249A.4.

ITEM 2. Amend subparagraph **79.3(2)"d"(27)** as follows:

(27) Home health agency services:

1. to 3. No change.

4. Physician, nurse practitioner, physician assistant, or clinical nurse specialist orders or medical orders.

ITEM 3. Amend paragraph **83.2(1)"e"** as follows:

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) to (3) No change.

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or ~~a~~ physician assistant.

ITEM 4. Amend paragraph **83.61(1)"k"** as follows:

k. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) to (3) No change.

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

ITEM 5. Amend paragraph **83.82(1)"j"** as follows:

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) to (3) No change.

(4) In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 3/10/21.